

Case Number:	CM14-0069953		
Date Assigned:	08/08/2014	Date of Injury:	10/04/2012
Decision Date:	09/23/2014	UR Denial Date:	04/23/2014
Priority:	Standard	Application Received:	05/15/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient is a 49-year-old female who has submitted a claim for cervical sprain / strain, cervical spine herniated disc, cervical spine radiculitis, lumbar spine sprain / strain, right shoulder sprain / strain, status post bilateral carpal tunnel release, and rule out right elbow internal derangement associated with an industrial injury date of 10/04/2012. Medical records from 2013 to 2014 were reviewed. Patient complained of moderate pain at the neck, low back, right shoulder and headache. Physical examination showed tenderness, spasm, and restricted range of motion of the cervical spine, lumbar spine, and right shoulder joint. Cervical compression test was positive. Kemp's test and Patrick FABERE test were positive. Motor strength, reflexes, and sensory exam were unremarkable. Urine drug screen from 01/27/2014, 09/24/2013 and 10/21/2013 showed positive levels for hydrocodone and hydromorphone. MRI of the cervical spine, dated 5/1/2013, demonstrated 3-mm retrolisthesis of C5 on C6, reduction in disc height and posterior end plate osteophytosis. A 4-mm broad-based posterior disk bulge with 4-mm inferior subligamentous extension and left paracentral region compatible with extrusion was noted. There was mild central canal and biforaminal narrowing. There was no nerve root impingement. Treatment to date has included bilateral carpal tunnel release, acupuncture, chiropractic care, and medications such as Robaxin, Norco, and Motrin (since 2013). Utilization review from 04/23/2014 denied the request for Open MRI without Contrast of the Lumbar Spine because of no documentation of red flag condition or neurologic deficits to warrant such; denied Chiropractic Treatment for the Cervical Spine because QME report cited worsening of symptoms secondary to manipulation therapy; denied Series of Epidural Injections for the Cervical Spine because of lack of specified levels intended for injection; denied Robaxin 750mg with 4 refills because long-term use was not recommended; denied Norco 10/325mg #120 with 4 refills because of lack of documented

functional improvement; and modified the request for Motrin 800mg #100 with 4 refills into zero refill because there was no documentation of functional restoration to support its continuing use.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Open MRI without Contrast of the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section, MRI.

Decision rationale: As stated on pages 303-304 of the ACOEM Practice Guidelines referenced by CA MTUS, imaging of the lumbar spine is recommended in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise, failure to respond to treatment, and consideration for surgery. In addition, Official Disability Guidelines recommends MRI for the lumbar spine for uncomplicated low back pain, with radiculopathy, after at least 1 month of conservative therapy, sooner if severe, or progressive neurologic deficit. In this case, patient complained of low back pain described as stabbing, sharp, and tight. Physical examination of the lumbar spine showed restricted range of motion. Motor strength, reflexes, and sensory exams were unremarkable. Kemp's test and Patrick FABERE test were positive. However, clinical manifestations were not consistent with radiculopathy to warrant further diagnostic procedure by utilizing MRI. There was no evident red flag sign present. There was no clear indication for the present request. Therefore, the request for Open MRI without Contrast of the Lumbar Spine is not medically necessary.

Chiropractic Treatment for the Cervical Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (updated 04/10/14), Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26, Manipulation Therapy Page(s): 58-59.

Decision rationale: As stated on pages 58-59 of CA MTUS Chronic Pain Medical Treatment Guidelines, several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. There should be some outward sign of subjective or objective improvement within the first 6 visits for continuing treatment. In this case, patient underwent chiropractic care previously. However, a QME report cited that it resulted to subjective worsening of symptoms. Moreover, the request failed to

specify number of sessions. Therefore, the request for Chiropractic Treatment for the Cervical Spine is not medically necessary.

Series of Epidural Injections for the Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 45.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26, Epidural Steroid Injection Page(s): 46.

Decision rationale: As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. In this case, patient complained of neck pain described as aching and tender. Physical examination of the cervical spine showed tenderness and painful range of motion. Reflexes and strength of bilateral upper extremities were normal. MRI of the cervical spine, dated 5/1/2013, demonstrated mild central canal and biforaminal narrowing at C5-C6. There was no nerve root impingement. However, clinical manifestations, as well as imaging findings were not consistent with radiculopathy to warrant epidural steroid injection. Moreover, the present request for series of injections is not guideline recommended because succeeding block is dependent on the efficacy of the previous one. Lastly, the present request failed to specify intended levels for injection. Guideline criteria were not met. Therefore, the request for Series of Epidural Injections for the Cervical Spine is not medically necessary.

Robaxin 750mg with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 64, 65.

Decision rationale: As stated on pages 64-65 of CA MTUS Chronic Pain Medical Treatment Guidelines, methocarbamol (Robaxin) is used to decrease muscle spasm in conditions such as low back pain. Its mechanism of action is related to central nervous system depressant effects. In this case, patient has been prescribed with Robaxin as early as 2013. However, there was no documentation concerning pain relief and functional improvement derived from its use. The medical necessity cannot be established due to insufficient information. Therefore, the request for Robaxin 750mg with 4 refills is not medically necessary.

Norco 10/325mg #120 with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26, Opioids Page(s): 78.

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on Norco since 2013. Previous urine drug screens showed consistent results with the prescribed medications. However, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Norco 10/325mg #120 with 4 refills is not medically necessary.

Motrin 800mg #100 with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, NSAIDs Page(s): 46.

Decision rationale: As stated on page 46 of the California MTUS Chronic Pain Medical Treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, patient has been on Motrin since 2013. However, there was no documentation concerning pain relief and functional improvement derived from its use. Long-term use is likewise not recommended. Therefore, the request for Motrin 800mg #100 with 4 refills is not medically necessary.